STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155586	A. BUILDING 01 B. WING	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN LIFE VILLAGES	6701 S ANTHONY BLVD FORT WAYNE, IN 46816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000				
	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/30/12 and 01/31/12 Facility Number: 000283 Provider Number: 155586 AIM Number: 100275020 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Lutheran Life Villages was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The main building is a three story building with a basement	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	determined to be of Type I (332) construction and is sprinklered with the exception of the basement. The Health and Rehabilitation building is a one story building of Type I(332) construction and was fully sprinklered. The main building has a fire alarm system with smoke detection in corridors, areas open to the corridors and all resident rooms. The Health and Rehabilitation building has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated smoke detector in the resident rooms except: Peerage wing resident rooms 321 to 355 and 358 to 364 which are occupied and AB extended wing and the Phrenic wing, which are currently closed. The facility has a capacity of 262 and had a census of 131 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/09/12. The facility was found not in compliance with the aforementioned regulatory			

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	requirements as evidenced by the following:			

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K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 sets of Physical Therapy double corridor doors closed and latched into the door frame. This deficient practice could affect any resident in or near the Physical Therapy room. Findings include: Based on observation with the Maintenance Director and the Maintenance Assistant Director on 01/30/12 at 1:50 p.m., the Physical Therapy corridor double doors lacked latching hardware and failed to latch into the door frame. This was acknowledged by the Maintenance Director at the time of observation.	K0018	**What measures were taken for residents directly affected?** No residents were directly affected by this deficient practice. **What measures were put in place to identify other residents at risk?** All residents are at risk to be affected by this deficient practice. The physical therapy doors have been installed in their current state for 10+ years with neither incident nor code violation. **What systemic change was put in place to ensure the deficient practice does not recur?** One (1) set of Dorma Model 8400LB door hardware is being ordered for the physical therapy doors. Installation will occur as soon as possible, subject to parts	03/01/2012

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	3.1-19(b)		and service availability from the third-party contractor. This hardware will latch into the casing and provide a panic bar exit device configuration to the laundry doors. All pertinent staff has been in-serviced on this physical plant update and the code requirements supporting it. **How will the corrective action be monitored?** The Director of Maintenance and/or designee will monitor the installation of any new double doors includes the installation of properly latching hardware.	

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K0029 SS=D	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1			
	Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 laundry rooms, a hazardous area, latched into the door frame. This deficient practice could affect any resident in the basement beauty shop or near the laundry room. Findings include: Based on an observation with the Maintenance Director and the Maintenance Assistant Director on 01/30/12 at 12:23 p.m., both sets of corridor double doors entering the laundry room lacked latching hardware and did not latch into the door frame. This was confirmed by the Maintenance Director at the time of observation. 3.1-19(b)	K0029	**What measures were taken for residents directly affected?** No residents were directly affected by this deficient practice. **What measures were put in place to identify other residents at risk?** All residents are at risk to be affected by this deficient practice. Both sets of doors have been installed in their current state for 10+ years with neither incident nor code violation. **What systemic change was put in place to ensure the deficient practice does not recur?** Two (2) sets of Dorma Model 8400LB door hardware are being ordered for the two (2) sets of laundry room doors. Installation will occur as soon as possible, subject to parts and service availability from the third-party contractor. This hardware will latch into the casing and provide	03/01/2012

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			a panic bar exit device configuration to the laundry doors. All pertinent staff has been in-serviced on this physical plant update and the code requirements supporting it. **How will the corrective action be monitored?** The Director of Maintenance and/or designee will monitor the installation of any new double doors includes the installation of properly latching hardware.	

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K0070 SS=D	Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8			
	Based on observation, interview and record review; the facility failed to provide a policy for the use of 1 of 1 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice is not in a resident care area but could affect any number of staff. Findings include: Based on an observation with the Maintenance Director and the Maintenance Assistant Director on 01/30/12 at 12:40 p.m., a space heater was in use in the Project Manager's office located in the basement. During the record review process on 01/30/12 at 12:00 p.m., the facility did not have a written policy regarding the use of space heaters. Based on interview with the Maintenance Director and the Maintenance Assistant Director at the time of record review and then again at	K0070	**What measures were taken for residents directly affected?** No residents were directly affected by this deficient practice. **What measures were put in place to identify other residents at risk?** All residents are at risk to be affected by this deficient practice. The heating device noted during the survey was in a non-resident care area. **What systemic change was put in place to ensure the deficient practice does not recur?** A policy addressing the use of portable space heaters in non-resident care areas has been written in accordance with NFPA 101, section 19.7.8. All pertinent staff has been in-serviced on this new practice. **How will the corrective action be monitored?** The Director of Maintenance and/or designee will monitor all offices on a routine basis weekly for 12 weeks and monthly	03/01/2012

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	the time of observation, the facility does not have a written policy regarding space heaters and space heaters are not allowed in the facility. 3.1-19(b)		thereafter for quality assurance.	

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K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 wet location resident care areas such as the main building third floor lounge was provided with ground fault circuit interrupter (GFCI) against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect any resident in the third floor lounge. Findings include: Based on observation with the Maintenance Director and the	K0147	**What measures were taken for residents directly affected?** No residents were directly affected by this deficient practice. **What measures were put in place to identify other residents at risk?** All residents are at risk to be affected by this deficient practice. All required outlets have been replaced with GFCI outlets. **What systemic change was put in place to ensure the deficient practice does not recur?** All facility electrical outlets meet compliance with life safety code. Any future outlets installed in similar areas will be of the ground fault interrupter (GFCI) type. All pertinent staff has been in-serviced on this new practice. **How will the corrective action be monitored?** The Director of Maintenance and/or designee will monitor the installation of any new electrical outlets to ensure the GFCI type is installed.	03/01/2012

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	Maintenance Assistant Director on 01/30/12 at 1:00 p.m., the main building third floor lounge had an electrical receptacle on the wall within three feet of a sink which was not provided with GFCI protection to prevent electric shock. When tested with a GFCI testing device the circuit was not interrupted. This was confirmed by the Maintenance Assistant Director at the time of observation. 3.1-19(b)			